



**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**Ernie Fletcher**  
Governor

275 E. Main Street, 6W-A  
Frankfort, KY 40621  
(502) 564-4321  
Fax: (502) 564-0509  
www.chfs.ky.gov

**Mark D. Birdwhistell**  
Secretary

**Shawn M. Crouch**  
Commissioner

November 28, 2007

Renard L. Murray, D.M.  
Associate Regional Administrator  
Centers for Medicare and Medicaid Services  
61 Forsyth Street, Suite 4T20  
Atlanta, Georgia 30303-8909

Dear Dr. Murray:

Kentucky Title XIX State Plan Transmittal No. 07-007  
Physician Reimbursement

Enclosed for your review and approval is Kentucky Title XIX Transmittal Number 07-007. This plan amendment implements the following items:

1. Establish coverage for risperidone and for drugs or biologicals which require special handling and are administered in a physician's office;
2. Increase evaluation and management service coverage from one/recipient/year to two/recipient/year and allow additional if prior authorized by the department;
3. Introduce a flat rate of \$72 per office visit for office visits conducted after standard office hours Monday through Friday after 5:00 pm or occurring after 12:00 pm on Saturday or anytime Sunday;
4. Rather than reimburse for anesthesia services based on an average amount of time, reimburse based on actual time;
5. Increase vaginal delivery-related anesthesia from \$200 to \$215 (not included in May 15 ordinary regulation);
6. Increase Cesarean section anesthesia from \$320 to \$335 (not included in May 15 ordinary regulation);
7. Increase Neuroxial labor anesthesia from \$335 to \$350 (not included in May 15 ordinary regulation);
8. Increase nondelivery-related anesthesia dollar conversion factor from \$13.86 to \$15.20 (not included May 15);


If additional information is needed, please contact my office at 502-564-4321.

Sincerely,

Shawn M. Crouch  
Commissioner

Enclosure

SC/NW/SO/KS

|   |  |   |                      |
|---|--|---|----------------------|
| DEPARTMENT OF HEALTH AND HUMAN SERVICES<br>HEALTH CARE FINANCING ADMINISTRATION   |  | FORM APPROVED<br>OMB NO. 0938-0193  |                      |
| <b>TRANSMITTAL AND NOTICE OF APPROVAL OF<br/>STATE PLAN MATERIAL</b>  |  | 1. TRANSMITTAL NUMBER:<br>07-007  | 2. STATE<br>Kentucky |
| <b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>  |  | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE<br>SOCIAL SECURITY ACT (MEDICAID)   |                      |
| TO: REGIONAL ADMINISTRATOR<br>HEALTH CARE FINANCING ADMINISTRATION<br>DEPARTMENT OF HEALTH AND HUMAN SERVICES   |  | 4. PROPOSED EFFECTIVE DATE<br>October 1, 2007   |                      |
| 5. TYPE OF PLAN MATERIAL (Check One):   |  |   |                      |
| <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT   |  |   |                      |
| COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)   |  |   |                      |
| 6. FEDERAL STATUTE/REGULATION CITATION:<br>42 CFR 447.10- 447.25  |  | 7. FEDERAL BUDGET IMPACT:<br>a. FFY 2007 - indeterminable<br>b. FFY 2008 - indeterminable   |                      |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:<br><br>Attachment 3.1-A p. 7.2.1, 7.2.1(a);<br>Attachment 3.1-B p. 21, 22; and<br>Attachment 4.19-B p. 20.1(b), 20.3(a), 20.4, 20.5                       |  | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION<br>OR ATTACHMENT (If Applicable):<br><br>Same                                       |                      |
| 10. SUBJECT OF AMENDMENT:<br>This plan amendment implements changes to physician reimbursement.   |  |   |                      |
| 11. GOVERNOR'S REVIEW (Check One):  |  |   |                      |
| <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT<br><input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED<br><input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL |  | <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Review delegated<br>to Commissioner, Department for Medicaid<br>Services |                      |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL:<br>   |  | 16. RETURN TO:  |                      |
| 13. TYPED NAME: Shawn M. Crouch   |  | Department for Medicaid Services<br>275 East Main Street 6W-A<br>Frankfort, Kentucky 40621  |                      |
| 14. TITLE: Commissioner, Department for Medicaid Services   |  |   |                      |
| 15. DATE SUBMITTED: November 28, 2007   |  |   |                      |
| FOR REGIONAL OFFICE USE ONLY  |  |   |                      |
| 17. DATE RECEIVED:  |  | 18. DATE APPROVED:  |                      |
| PLAN APPROVED - ONE COPY ATTACHED   |  |   |                      |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL:  |  | 20. SIGNATURE OF REGIONAL OFFICIAL:   |                      |
| 21. TYPED NAME:   |  | 22. TITLE:  |                      |
| 23. REMARKS:  |  |   |                      |

---

5. Physicians' Services

- A. Coverage for certain initial visits is limited to one visit per patient per physician per three (3) year period. This limitation applies to the following procedures:

New patient evaluation and management office or other outpatient services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

New patient evaluation and management home or custodial care services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

New patient evaluation and management preventive medicine services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

- B. Coverage for an evaluation and management service with a corresponding CPT code of 99214 or 99215 shall be limited to two (2) per recipient per year, per physician. An evaluation and management service with a corresponding CPT of 99214 or 99215 exceeding the limit DMS will reimburse any such claim as a 99213 evaluation and management visit.
- C. Outpatient psychiatric service procedures rendered by other than board- eligible and board-certified psychiatrists are limited to four (4) such procedures per patient per physician per twelve (12) month period.
- D. Coverage for laboratory procedures performed in the physician's office is limited to those procedures for which the physician's office is CLIA certified with the exception of urinalysis performed by dipstick or reagent tablet only which shall not be payable as a separate service to physician providers. The fee for this, or comparable lab tests performed by reagent strip or tablet, excluding blood glucose, shall be included in the evaluation and management service reimbursement provided on the same date of service for the same provider.

The professional component of laboratory procedures performed by board certified pathologists in a hospital setting or an outpatient surgical clinic are covered so long as the physician has an agreement with the hospital or outpatient surgical clinic for the provision of laboratory procedures.

- E. A patient "locked in" to one physician due to over-utilization may receive physician services only from his/her lock-in provider except in the case of an emergency or referral.
- F. The cost of preparations used in injections is not considered a covered benefit, except for the following:
  - (1) The Rhogam injection.
  - (2) Injectable antineoplastic chemotherapy administered to recipients with a malignancy diagnosis contained in the Association of Community Cancer Centers Compendia-Based Drug Bulletin, as adopted by Medicare.
  - (3) Depo Provera provided in the physician office setting.
  - (4) Penicillin G (up to 600,000 I.U.) and Ceftriaxone (250 mg.).
  - (5) Long acting injectable risperidone.
  - (6) An injectable, infused or inhaled drug or biological that is:
    - a. Not typically self-administered;
    - b. Not excluded as a noncovered immunization or vaccine; and
    - c. Requires special handling, storage, shipping, dosing or administration.
- G. Coverage for standard treadmill stress test procedures are limited to three (3) per six (6) month period per recipient. If more than three (3) are billed within a six (6) month period, documentation justifying medical necessity shall be required.
- H. Physician - patient telephone contacts are not covered.
- I. Coverage of a physician service is contingent upon direct physician/patient interaction except in the following cases:
  - (1) A service furnished by a resident under the medical direction of a teaching physician in accordance with 42 CFR 415.
  - (2) A service furnished by a physician assistant acting as agent of a supervising physician and performed within the physician assistant's scope of certification.

---

5. Physicians' Services

- A. Coverage for certain initial visits is limited to one visit per patient per physician per three (3) year period. This limitation applies to the following procedures:

New patient evaluation and management office or other outpatient services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

New patient evaluation and management home or custodial care services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

New patient evaluation and management preventive medicine services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

- B. Coverage for an evaluation and management service with a corresponding CPT code of 99214 or 99215 shall be limited to two (2) per recipient per year, per physician. An evaluation and management service with a corresponding CPT of 99214 or 99215 exceeding the limit DMS will reimburse any such claim as a 99213 evaluation and management visit.
- C. Outpatient psychiatric service procedures rendered by other than board- eligible and board-certified psychiatrists are limited to four (4) such procedures per patient per physician per twelve (12) month period.
- D. Coverage for laboratory procedures performed in the physician's office is limited to those procedures for which the physician's office is CLIA certified with the exception of urinalysis performed by dipstick or reagent tablet only which shall not be payable as a separate service to physician providers. The fee for this, or comparable lab tests performed by reagent strip or tablet, excluding blood glucose, shall be included in the evaluation and management service reimbursement provided on the same date of service for the same provider.

The professional component of laboratory procedures performed by board certified pathologists in a hospital setting or an outpatient surgical clinic are covered so long as the physician has an agreement with the hospital or outpatient surgical clinic for the provision of laboratory procedures.

- E. A patient "locked in" to one physician due to over-utilization may receive physician services only from his/her lock-in provider except in the case of an emergency or referral.
- F. The cost of preparations used in injections is not considered a covered benefit, except for the following:
  - (1) The Rhogam injection.
  - (2) Injectable antineoplastic chemotherapy administered to recipients with a malignancy diagnosis contained in the Association of Community Cancer Centers Compendia- Based Drug Bulletin, as adopted by Medicare.
  - (3) Depo Provera provided in the physician office setting.
  - (4) Penicillin G (up to 600,000 I.U.) and Ceftriaxone (250 mg.).
  - (5) Long acting injectable risperidone.
  - (6) An injectable, infused or inhaled drug or biological that is:
    - a. Not typically self-administered;
    - b. Not excluded as a noncovered immunization or vaccine; and
    - c. Requires special handling, storage, shipping, dosing or administration.
- G. Coverage for standard treadmill stress test procedures are limited to three (3) per six (6) month period per recipient. If more than three (3) are billed within a six (6) month period, documentation justifying medical necessity shall be required.
- H. Physician - patient telephone contacts are not covered.
- I. Coverage of a physician service is contingent upon direct physician/patient interaction except in the following cases:
  - (1) A service furnished by a resident under the medical direction of a teaching physician in accordance with 42 CFR 415.
  - (2) A service furnished by a physician assistant acting as agent of a supervising physician and performed within the physician assistant's scope of certification.

5. The department shall reimburse the following drugs at the lesser of the actual billed charge or average wholesale price (AWP) minus ten (10) percent if the drug is administered in a physician's office:
- a. Rho (D) immune globulin injection;
  - b. An injectable antineoplastic drug;
  - c. Medroxyprogesterone acetate for contraceptive use, 150 mg;
  - d. Penicillin G benzathine injection;
  - e. Ceftriaxone sodium injection;
  - f. Intravenous immune globulin injection;
  - g. Sodium hyaluronate or hylan G-F for intra-articular injection;
  - h. An intrauterine contraceptive device;
  - i. An implantable contraceptive device;
  - j. Long acting injectable risperidone; or
  - k. An injectable, infused or inhaled drug or biological that is:
    - (1) Not typically self-administered;
    - (2) Not excluded as a noncovered immunization or vaccine; and
    - (3) Requires special handling, storage, shipping, dosing or administration.

If long acting injectable risperidone is provided to an individual covered under both Medicaid and Medicare and administered by a physician employed by a community mental health center or other licensed medical professional employed by a community mental health center, the department shall provide reimbursement at the same rate it reimburses for these drugs provided to a Medicaid recipient, except that the department shall reduce reimbursement by the amount of the third party obligation.

(3) The flat rate for a service shall be established by multiplying the dollar conversion factor by the sum of the RVU units plus the actual minutes. RBRVS units shall be multiplied by a dollar conversion factor to arrive at the fixed upper limit. The dollar conversion factors are as follows:

| <u>Types of Service</u>         | <u>Kentucky Conversion Factor</u> |
|---------------------------------|-----------------------------------|
| Deliveries                      | Not applicable                    |
| Non-delivery Related Anesthesia | \$15.20                           |
| Non-anesthesia Related Services | \$29.67                           |

(4) The fixed upper limit for a covered anesthesia service shall not exceed the upper limit that was in effect on June 1, 2006 by more than twenty (20) percent. The reimbursement shall not decrease below the upper payment limit in effect on June 1, 2006.

C. Reimbursement Exceptions.

(1) Physicians will be reimbursed for the administration of specified immunizations obtained free from the Department for Public Health through the Vaccines for Children Program to provide immunizations for Medicaid recipients under the age of nineteen (19). For Medicaid recipients of age nineteen (19) and over, physicians will be reimbursed for the administration cost of the influenza vaccination, and the cost of the vaccination will be paid by the recipient. The appropriate reimbursement from Medicaid will be made to the physician upon receipt of notice from the physicians that the vaccinations were used to provide immunizations to Medicaid recipients.

(2) Payments for obstetrical delivery services provided on or after September 15, 1995 shall be reimbursed the lesser of the actual billed charge or at the standard fixed fee paid by type of procedure. The obstetrical services and fixed fees are:

|   |          |
|---|----------|
| Delivery only                               | \$870.00 |
| Vaginal delivery including postpartum care  | \$900.00 |
| Cesarean delivery only                      | \$870.00 |
| Cesarean delivery including postpartum care | \$900.00 |

(3) For delivery-related anesthesia services provided on or after July 1, 2006, a physician shall be reimbursed the lesser of the actual billed charge or a standard fixed fee paid by type of procedure. Those procedures and fixed fees are:

|  |       |
|--|-------|
| Vaginal delivery   | \$215 |
| Cesarean section   | \$335 |
| Neuroaxial labor anesthesia for a vaginal delivery or cesarean section                                 | \$350 |
| Additional anesthesia for cesarean delivery following neuroaxial labor anesthesia for vaginal delivery | \$25  |
| Additional anesthesia for cesarean hysterectomy following neuroaxial labor anesthesia                  | \$25  |

(4) Payment for individuals eligible for coverage under Medicare Part B is made, in accordance with Sections A and B and items (1) through (4) and (6) of this section within the individual's Medicare deductible and coinsurance liability.

(5) For services provided on or after July 1, 1990, family practice physicians practicing in geographic areas with no more than one (1) primary care physician per 5,000 population, as reported by the United States Department of Health and Human Services, shall be reimbursed at the physicians' usual and customary actual billed charges up to 125 percent of the fixed upper limit per procedure established by the Department.

(6) For services provided on or after July 1, 1990, physician laboratory services shall be reimbursed based on the Medicare allowable payment rates. For laboratory services with no established allowable payment rate, the payment shall be sixty-five (65) percent of the usual and customary actual billed charges.

(7) Procedures specified by Medicare and published annually in the Federal Register and which are commonly performed in the physician's office are subject to outpatient limits if provided at alternative sites and shall be paid adjusted rates to take into account the change in usual site of services.

- (7) Payments for the injection procedure for chemonucleolysis of intervertebral disk(s), lumbar, shall be paid the lesser of the actual billed charge or at a fixed upper limit of \$793.50 as established by the Department.
- (8) Specified family planning procedures performed in the physician office setting shall be reimbursed at the lesser of the actual billed charge or the established RBRVS *fee* plus actual cost of the supply minus ten percent.
- (9) Certain injectable antibiotics and antineoplastics, and contraceptives shall be reimbursed at the lesser of the actual billed charge or at the average wholesale price of the medication supply minus ten (10) percent.
- (10) When oral surgeons render services which are within the scope of their licensed oral surgery practice, they shall be reimbursed as physicians (i.e., in the manner described above).
- (11) For a practice-related service provided by a physician assistant, the participating physician shall be reimbursed at the usual and customary actual billed charge up to the fixed upper limit per procedure established by the Department for Medicaid Services at seventy-five (75) percent of the physician's fixed upper limit per procedure.
- (12) Any physician participating in the lock-in program will be paid a \$10.00 per month lock-in fee for provision of patient management services for each recipient locked-in to that physician.
- (13) Supplemental payments will be made for services provided by medical school faculty physicians either directly or as supervisors of residents who have entered into contractual agreements with medical schools for the assignment of payments in accordance with 42 CFR 447.10.
- (14) The supplemental payments will be made on a quarterly basis in an amount which when combined with other payments under the plan, does not exceed the physicians' usual and customary charges.
- (15) A second anesthesia service provided by a provider to a recipient on the same date of service shall be reimbursed at the Medicaid Physician Fee Schedule amount established by the Department;
- (16) A bilateral procedure shall be reimbursed at one hundred fifty (150) percent of the amount established by the Department;
- (17) A fixed rate of twenty-five (25) dollars for anesthesia add-on services provided to a recipient under age one (1) and over age seventy (70).
- (18) Physicians will be reimbursed for the administration of the influenza vaccine to a Medicaid recipient of any age.
- (19) The department shall reimburse a flat rate of seventy-two (72) dollars per office visit for an office visit beginning after 5:00 pm Monday through Friday or beginning after 12:00 pm on Saturday through the remainder of weekend.
- (20) Deep sedation of general anesthesia relating to oral surgery performed by an oral surgeon shall have a fixed rate of \$150.

- D. Assurances. The state hereby assures that (1) payment for physician services are consistent with efficiency, economy, and quality of care (42 CFR 447.200); and (2) payments for services do not exceed the prevailing charges in the locality for comparable services under comparable circumstances.